Ninth District Opportunity, Inc.
Community Action Agency

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my Protected Health Information (PHI) as described below.

I have the right to revoke this authorization at any time by giving written notice of my revocation to NINTH DISTRICT OPPORTUNITY. I understand that my revocation will not affect any action taken before my revocation notice is received. I also understand that PHI used or disclosed under the provision of this authorization may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

(i) My past, present, or future health condition, treatment received, or future payment for the provision of health care to me.

The following individual, organization, or class of persons (*e.g.*, group of individuals within the organization) is authorized to use or disclose my protected health information:

_____
_____
_____

The protected health information that may be used and disclosed is as follows:
[Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims]

_____
_____
_____
_____
_____

My protected health information will be used or disclosed for the following purpose(s):
[Describe the reason for each use and disclosure of the protected health information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual".]

_____
_____
_____
_____
_____

This authorization expires: *[Identify specific date or event]* _____

_____

_____ _____
Signature of Individual or Personal Representative Date

_____
Name of Individual or Personal Representative

_____
Description of Personal Representative's Authority

NOTE: Provide the individual with a signed copy of the authorization.